STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED		
			B. WING		11/05/2014
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	ROVIDER OR SUPPLIE	R		/ 10TH ST	
BRIDGE AT GARDEN PLAZA				IAPOLIS, IN 46234	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R000000					
	This visit was fo	or a State Residential	R000000		
	Licensure Surve	ey.			
	This visit includ	led the Investigation of			
		_			
	Complaints IN0	0150630 and			
	IN00154770.				
	Complaint IN00	1156630 - Substantiated.			
	No deficiencies	related to the allegations			
	are cited.				
	Complaint IN00154770 -				
	Unsubstantiated due to lack of evidence.				
	Olisubstantiated due to lack of evidence.				
	Survey dates: November 3 and 5, 2014.				
	Survey dates. IV	ovember 5 and 5, 2014.			
	Facility Number	r: 005616			
	Provider Number				
	AIM Number: N	N/A			
	g =				
	Survey Team:				
	Kewanna Gordo				
	Tracina Moody,	RN			
	Census bed type	e:			
	Residential: 81				
	Total: 81				
	10141. 01				
	Cancus novor to	me.			
	Census payor ty	pc.			
	Other: 81				
	Total: 81				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: IURN11 Facility ID: 005616 If continuation sheet Page 1 of 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		B. WING			11/05/	2014	
NAME OF PROVIDER OR SUPPLIER BRIDGE AT GARDEN PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 8614 W 10TH ST INDIANAPOLIS, IN 46234				
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID		PROVIDERIG BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.		rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	ic.	DATE
	with 410 IAC 16 Quality review c	ompleted 11/9/14 by					
R000273	Quality review completed 11/9/14 by Brenda Marshall, RN 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure frozen foods were stored at zero degrees Fahrenheit or below, failed to ensure food was loosely covered while cooling to protect from overhead contamination, and failed to ensure employees wore hair restraints near exposed food and clean equipment. These deficient practices had the potential to affect 74 of 74 residents who consumed food from the facility kitchen. Findings include: 1. On 11/3/14 at 10:05 a.m. and 11:16 a.m., the dietary manager indicated the temperature of the walk-in freezer was 9		R000	273	The freezer fan motor was replaced on December 8, 2014 enhance the proper freezer temperatures. The Dietary Manger will continue to do dail freezer, refrigerator readings to verify temperatures are below zero. The current freezer logs since December 8th has met to State requirements. The Gene Manager will check the logs weekly to verify compliance. 2 Staff has been instructed on the requirement to have all iter properly covered in the walk in cooler. The dietary manager is checking daily for compliance. The cleaning of the covers has been altered to be completed during off times of service. 3 All staff is required to wear proper hair restraints during we hours in the kitchen. An inservitaining was provided to the standard to the reasons for hair restraint.	y o he eral ms i s ork ice aff	12/12/2014

State Form Event ID: IURN11 Facility ID: 005616 If continuation sheet Page 2 of 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/05/2014				
NAME OF PROVIDER OR SUPPLIER BRIDGE AT GARDEN PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 8614 W 10TH ST INDIANAPOLIS, IN 46234					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	AT GARDEN PLAZA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			the community policy and procedure as well as the citation details. Hats and hainets has been provided for alkitchen and dining staff for continued compliance. The dietary manger and dining sedirector will be responsible for monitoring for daily compliance. The general manager will morandomly during meal service compliance.	rvice r ce. nitor			
	the line freezer to	perature logs indicated emperature was above arenheit on the following						

State Form Event ID: IURN11 Facility ID: 005616 If continuation sheet Page 3 of 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 11/05/	ETED		
NAME OF PROVIDER OR SUPPLIER BRIDGE AT GARDEN PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 8614 W 10TH ST INDIANAPOLIS, IN 46234					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	AT GARDEN PLAZA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL							

State Form Event ID: IURN11 Facility ID: 005616 If continuation sheet Page 4 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 11/05	LETED			
NAME OF PROVIDER OR SUPPLIER BRIDGE AT GARDEN PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 8614 W 10TH ST INDIANAPOLIS, IN 46234					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE		
	a.m., the Dietary pies in the walk- to be covered in	iew on 11/3/14 at 11:19 Manager indicated the in cooler were supposed the cooler. He indicated covers were not used re being cleaned.						
	On 11/5/14 at 8:45 a.m., the administrator provided the current refrigerator storage policy, dated 12/12/13. The refrigerator policy indicated food should be wrapped properly to minimize cross-contamination and preserve quality.							
	3. On 11/3/14 at 10:18 a.m., Dishwasher Employee #1 was observed without a hair restraint in the dishroom putting away clean pans and dishes.							
	Employee #1 wa	:15 a.m., Dishwasher s observed without a hair pans and dishes through						
	and the Dietary I at the food service	:16 a.m., the sous chef Manager were observed the line near prepared at or hair restraint.						
	without hair rest the kitchen next	:25 a.m., four servers raints were observed in to the food line picking ates of food. Dishwasher						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED				
		B. WIN			11/05/	/2014			
E OF P					ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	PROVIDER OR SUPPLIE	R		8614 W	10TH ST				
BRIDGE	AT GARDEN PLAZ	ZA		INDIANAPOLIS, IN 46234					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	1 2	as observed without a hair							
	restraint to enter	the kitchen and walk							
	past the food sea	rvice line.							
	During an interview on 11/3/14 at 11:27								
	a.m., the Dietary Manager indicated staff								
	was required to wear hair restraints in the								
	kitchen.								
	Kitchen.								
	On 11/5/14 at 8:	45 a.m., the							
		rovided the current dress							
		ed 3/1/09. The dress							
		cated employees working							
	in the kitchen must wear hair restraints,								
	and depending upon working areas								
associates with long hair may be required									
	to wear a hair no	et.							
	5-5.1 (f)								

State Form Event ID: IURN11 Facility ID: 005616 If continuation sheet Page 6 of 6